



AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Requests for Mental/Behavioral Health records MUST be made through Counseling and Psychological Services, please call 847-491-2151.

Patient Name (Please Print) _____ Date of Birth _____
Name as a student (if different than above) _____ Student ID _____ Year Entered NU _____
E-mail _____ Phone _____

PLEASE RELEASE THE FOLLOWING HEALTH INFORMATION:

CHECK OFF EACH ITEM TO BE RELEASED. Requests for HIV/AIDS and/or Alcohol/Drug records require that you initial below.

Be as specific as possible:

_____ X-Ray Report _____ Initial for release of **Alcohol/Drug** record
_____ X-Ray Film – Charge applies _____ Initial for release of **HIV/AIDS** record
_____ TB Test Result
_____ Immunizations – Specify from Evanston or Chicago campus record: _____
_____ Physical Examination
_____ Lab Report(s) – List type of report(s) or approximate date(s): _____
_____ Visit Note(s) – List approximate dates: _____
_____ Other (specify): _____

ENTIRE HEALTH RECORD - \$25.00 Charge applies unless sent to another healthcare provider.

Reason for requesting information (e.g. further care, insurance claim, etc.): _____

I AUTHORIZE THE HEALTH SERVICE TO RELEASE MY HEALTH INFORMATION TO (Recipient):

NOTE: If authorizing release to multiple recipients, a separate form must be submitted for each recipient.

Name _____ Phone (Required for all fax requests) _____
Address _____ Fax _____
City _____ State _____ Zip Code _____

Initial below to identify how you want your health information released to the recipient:

_____ **MAIL** _____ **FAX** - 10 page maximum, student will be contacted if request exceeds limit _____ **Phone/Verbal**
_____ **PICK-UP** - When my records are ready to be picked up, notify me by: _____ E-mail _____ Phone _____

MAIL THIS FORM TO: Northwestern University Health Service, Health Information Management Services, 633 Emerson Street, Evanston, Illinois 60208-4000 **OR FAX TO:** 847-491-8699

***A \$25.00 CHARGE APPLIES FOR A COPY OF AN ENTIRE HEALTH RECORD UNLESS SENT TO ANOTHER HEALTHCARE PROVIDER. PAYMENT MUST BE MADE PRIOR TO RECORDS BEING RELEASED. CALL 847-491-2139 FOR DETAILS ON CHARGES FOR RELEASE OF X-RAY FILMS. CHECKS SHOULD BE MADE PAYABLE TO NORTHWESTERN UNIVERSITY.**

REQUESTS ARE PROCESSED WITHIN 3-5 BUSINESS DAYS OF RECEIPT.

Call 847-491-2142 if you have questions about your release.

NOTICE TO PATIENT

I fully understand that my medical record and health information for the above date may contain alcohol/drug abuse, and/or Acquired Immune Deficiency Syndrome/HIV test results and/or mental health information and/or other information. I understand that any of the above selected records may contain medical information from outside sources and authorize NUHS to release these records and health information if necessary for continuity of care or if I have requested my complete record. I understand that I have the right to inspect and/or obtain a copy, (for the appropriate fee) of my medical record prior to disclosure. I understand that this consent applies both to written and verbal release of information and is valid for 90 days from the date of signature, or until calendar date _____. I understand that I may revoke this consent at any time by giving written notice to Health Information Management Services of Northwestern University Health Service. I absolve Northwestern University and its agents or employees from any legal liability which may arise from the disclosure of this information.

Signature of patient or authorized legal guardian

Date

Relationship to patient, if signed by authorized representative

Date

Signature of staff member who received form at NUHS

Date

For Office Use Only _____

Number of pages _____ Date sent/initials _____ Date ready for pick-up _____